

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for the service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency medical services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost sharing amount (such as copayments, coinsurance and deductibles.) You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services. *Note: if you receive services in New York, and your insurance ID card says "fully insured coverage," you can't give written consent and give up your protections not to be balance billed for post-stabilization services.*

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.



No Surprise Billing Disclosure Notice

Patient Identification

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections. *Note: if you receive services in New York, and your insurance ID card says "fully insured coverage," you can't give up your protections for these other services if they are a surprise bill. Surprise bills are when you're at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided.*

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe on the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed:

- **Any patient** may visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. The federal phone number for information and complaints at 1-800-985-3059.
- **If you have coverage subject to New York law** ("fully insured coverage"), contact the New York State Dept of Financial Services at 1-800-342-3736 or email surprisemedicalbills@dfs.ny.gov. You may also visit https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills or <https://www.dfs.ny.gov/IDR> for more information about your rights under New York law.
 - For a list of AHN contracted (in-network) providers in New York, visit: <https://www.ahn.org/content/dam/ahn/en/dmxahn/documents/locations/westfield-memorial-hospital/ahn-providers-list.pdf>
 - For a list of AHN contracted (in-network) health plans in New York, visit: <https://www.ahn.org/patients-visitors/patients/financial-services/insurance-coverage>
- **If you have coverage subject to Pennsylvania law**, The Pennsylvania Insurance Department is the agency coordinating enforcement with state agencies that have oversight over providers and facilities you may contact the Pennsylvania Department of Insurance Consumer Services Bureau at 1-877-881-6399, or visit www.insurance.pa.gov/nosurprises for information or to file a complaint.



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Note: The Federal No Surprises Act Rights and Protections Against Surprise Medical Bills does not apply to programs like Medicare, Medicare Advantage, Medicaid, Managed Medicaid, Medigap, Children’s Health Insurance Program (CHIP), Indian Health Services, U.S. Department of Veterans Affairs (VA), and standalone Dental or Vision Plans.



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